IN SUPPORT OF AN AMENDMENT TO THE SUPPLEMENTAL APPROPRIATIONS BILL PROVIDING COMPENSATION TO THE FAMILIES OF THE RON BROWN PLANE CRASH IN CROATIA

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 6, 1999

Ms. NORTON. Mr. Speaker, after much soul searching, the families of the victims of the military plane carrying Commerce Secretary Ron Brown that crashed in Croatia on April 3, 1996, have allowed us to introduce this amendment. It would provide up to $2 million in compensation for each of the families of the tragic accident. This amendment is not what the families requested, nor is it what I sought when I first introduced the Ron Brown Tort Equality Act on April 15, 1997. Although this amendment would close the books on the accident, it would not render complete justice to the families; would do nothing to assure that there would not be similar victims of military aircraft in the future; and would have no deterrent effect to ward off serious negligence in the future. Yet surely this amendment is what is minimally required.

The Ron Brown Tort Equality Act had nearly fifty cosponsors in the last Congress and we are on our way to that and more now. This is a notably bipartisan bill in no small part because the victims originated in 15 states and the District of Columbia. The Ron Brown Act would allow federal civilian employees or their families to sue the federal government but only for gross negligence by its officers or employees and only for compensatory damages. Because there will be few instances where gross negligence can be shown, this is a small change in our law. There also were non-federal employees on that fated plane for whom no compensation is possible today. Astonishingly, federal law does not allow compensation when private citizens are killed or injured overseas. Yet, private citizens can sue under the Act for the same injuries when they occur in this country. The Ron Brown Act would allow individuals who do not work for the federal government, or their families, to sue the United States for negligent or wrongful acts or omissions that occur in a foreign country.

This tragic accident yielded great sorrow and mourning by the nation and members of this body. The mourning period is over, colleagues. It is time now to compensate the families.

NEW DIRECTION FOR OUR NATION'S HEALTH CARE

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 6, 1999

Ms. SCHAKOWSKY. Mr. Speaker, ''The crisis in American health care is real and getting worse.'' Those words appeared in an editorial today in The Washington Post, written by two distinguished scholars, former U.S. Surgeon General C. Everett Koop and John C. Baldwin, vice president for health affairs at Dartmouth College.

I hope my colleagues will take a few minutes to read about the state of health care in our nation. Dr. Koop and Dr. Baldwin pointedly stress that universal access to health care must become a national commitment and will require a national investment. As important, they argue against the idea that health care should be treated as a commodity, saying that ''(w)e must rid ourselves of the delusion that it is a business, like any other business.''

At a time when 16 percent of Americans have no health insurance, health care costs are skyrocketing, and medical decisions are made by HMO executives beholden to shareholders, bold solutions are needed. As Dr. Koop and Dr. Baldwin state, ''(o)ur problem is a failure of distribution, a failure to extend care to all of those who need it and a failure to recognize the importance of applying scientific rigor to the problems of broad-based health care delivery. If state-of-the-art American medicine were offered to our citizens in a comprehensive way, our levels of public health would be unexcelled.''

They also recognize that we can not continue on our current path, to spend more than any industrialized nation in the world while providing less. Correctly, they conclude that ''the movement over the past few years to turn health care into a 'business' through health maintenance organizations and other stratagems has not worked to the satisfaction of most Americans.'' Indeed, it is time for a new direction.

The crisis in American health care is real and getting worse. A record 16 percent of Americans now have no health insurance—a grave situation that will not be solved by conventional business models. Indeed, the movement over the past few years to turn health care into a ''business'' through health maintenance organizations and other stratagems has not worked to the satisfaction of most Americans.

Frustrated, legislators across the political spectrum pursue the notion that legislative tinkering will solve the problems. But since the derailment of President Clinton's health reform plan in his first term—and particularly since the elections of 1994—the country has slipped or been lulled into a false sense of confidence that the real and worsening crisis in American health care can somehow be solved by implementation of ''reforms'' based on such euphemistic concepts as ''gatekeepers,'' ''pathways,'' ''preexisting conditions,'' ''risk pools'' and other impediments to access—all disguised as tools of efficient management.

To be sure, health care costs have risen too rapidly in the past 20 years. Highly paid providers and administrators and exceedingly profitable health care corporations have played a role, though their contributions to rising costs have been less important than the effects of an aging population and the continual introduction of new technologies. But we must not abrogate our responsibility to make difficult choices in the vain hope that a ''free market,'' profit-based system somehow will solve the problem for us without our doing anything.

If health care were a business, it would be a strange one indeed—one in which many sectors of the ''market'' could never be profitable. People with AIDS, most children with congenital, chronic or catastrophic illness, poor people, old people and most truly sick people could never pay enough to make caring for them profitable.

Over the past few years, nevertheless, we have often heard that ''health care is like any other product; you buy what you can afford.'' Most proponents of this idea quickly add that of course ''basic'' health care should be provided. But what does this mean? Suppose two children, one in an uninsured family and one in a well-insured one, both developed leukemia, a treatable and often curable illness. What is the basic level of care each child is entitled to?

HMO executives properly emphasize that their responsibility is to shareholders. That responsibility is defined in terms of profit and stock price. The volume and market-share considerations in this ''business'' require aggressive pricing. Sustained profits, in turn, require aggressive cost-cutting. This results, inevitably, in restriction of access and withholding of care.

Both these things may well be necessary to improve efficiency and cut costs. But do we really want to relegate such decisions to analysts within the health care industry, or should we assert the public interest in these crucial ethical, societal and medical issues?

We nod our heads when we are told that the percentage of our GNP spent on health care is ''too high'' and that inefficiency, the ''fat'' in the system, results in its providing less effective care than is available in other industrialized nations that spend a lesser percentage. But this argument is specious. The American biomedical research endeavor, supported in the main by the taxpayers, had led the world for more than 30 years and continues to do so. Attendance at any medical scientific meeting anywhere in the world confirms this hegemony and affirms the enormous respect the rest of the world has for American medicine.

Our system is not a failure. The dramatic decline in deaths from heart disease is salient evidence for the phenomenal success of technologically advanced American medical care for those who can afford it. Our problem is a failure of distribution, a failure to extend care to all of those who need it and a failure to recognize the importance of applying scientific rigor to the problems of broad-based health care delivery. If state-of-the-art American medicine were offered to our citizens in a comprehensive way, our levels of public health would be unexcelled.

Like education (also, in important ways, not a business), the public health is a national investment and a crucial one. Could we justify a ''privatized'' educational system that denied access to slower learners unable to pay—i.e., the children who need help the most? When you consider that we spend more on leisure than on health care (22 percent more just on recreation, restaurant meals, tobacco and foreign travel), is the percentage of the GNP we spend on health care really so inappropriate?

The failure in distribution of health care is the product of our tacit acquiescence in the notion that health care access rightly depends on ability to pay. This idea has become, for

many, a point of philosophical and ideological zeal.

It is long past time we acknowledged that broad-based access to health care will be an exceedingly expensive proposition. We must rid ourselves of the delusion that it is a business, like any other business.

The problem can be fixed. Forming a public consensus on this matter is a mighty and politically perilous challenge, requiring leadership and the courage to state that adequate health care is an appropriate goal for this country and a vital national investment. These are, indeed, treacherous waters. Can we get away from the clichés about ''socialized medicine'' and the hackneyed references to overly bureaucratized, centralized, inefficient postwar European health systems?

As world leaders in science, business and organizational management, we are capable of something new. We should maintain our commitment to the advancement of biomedical science for the public good and couple it with the management skills that have created our vibrant, competitive economy, and apply both in creating a national policy of investment in health.

John C. Baldwin is vice president for health affairs at Dartmouth College and dean of its medical school. C. Everett Koop is senior scholar at the Koop Institute there and a former U.S. surgeon general.

PERSONAL EXPLANATION

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 6, 1999

Mr. BECERRA. Mr. Speaker, due to a commitment in my district on Wednesday, May 5, 1999, I was unable to cast my floor vote on rollcall numbers 108 through 115. The votes I missed include rollcall vote 108 on Approving the Journal; rollcall vote 109 on Ordering the Previous Question; rollcall vote 110 on the Hyde amendment to H.R. 833, the Bankruptcy Reform Act; rollcall vote 111 on the Moran amendment to H.R. 833; rollcall vote 112 on the Conyers amendment to H.R. 833; rollcall vote 113 on the Watt amendment to H.R. 833; rollcall vote 114 on the Nadler substitute amendment to H.R. 833; and rollcall vote 115 on passage of H.R. 833.

Had I been present for the preceding votes, I would have voted ''yes'' on rollcall votes 108, 110, 111, 112, 113, and 114. I would have voted ''no'' on rollcall votes 109 and 115.

PRIVATIZATION: THE WRONG PRESCRIPTION FOR MEDICARE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 6, 1999

Mr. STARK. Mr. Speaker, several Members have touted the idea that Medicare should be turned over to the private sector. Although they say that privatization will save the program, their true motivation is to irreparably damage Medicare to the point that there is nothing left to salvage. In the words of former speaker Newt Gingrich, they want Medicare to ''wither on the vine.''

Republicans have always intended to destroy Medicare. While they have found new ways to disguise their message over the years, their intention remains the same: get government out of health care no matter what the cost. ''Privatization'' is just another one of their ploys.

The truth is that the private sector cannot provide high quality health services to disabled and elderly Americans. Especially not at a lower cost.

Medicare was originally created to fill in the gap of health insurance coverage for older Americans, and later the disabled. Before Medicare, the private sector either refused to provide insurance coverage to the elderly, or made the coverage so expensive that seniors could not afford to pay the premiums. Lack of health coverage meant having to pay for health care out of their limited retirement incomes. This left many elderly poverty stricken.

Today the health coverage problem for older Americans is getting worse, not better. The fastest growing number of uninsured are people age 55–62, an even younger group than when Medicare was first established. Rather than extending coverage to this uninsurable group, Republicans insist on doing nothing, even though the President's Medicare early-buy proposal would have cost nothing.

Why should we believe that private sector insurers will put their financial interests aside and compete to provide coverage for an older, sicker population when evidence suggests that they will not? Especially as costs for the chronically ill continue to rise.

Republicans have also claimed that the private sector will save money for Medicare. This is simply not true. Over the past thirty years, Medicare's costs have mirrored those of FEHBP and the private sector, even though Medicare covers an older, sicker population. Recent evidence shows that private sector costs are now rising faster than Medicare's.

Last fall Medicare+Choice plans abandoned 400,000 Medicare beneficiaries claiming that the Medicare rates were too low to cover this population. This suggest that health plans will charge ever more than we currently pay them, not less.

Privatizing Medicare will not improve quality, either. Paul Ellwood, the ''father of managed care,'' recently stated that the private sector is incapable of improving quality or correcting for the extreme variation in health services across the country and that government intervention is necessary and inevitable. In his words, ''Market forces will never work to improve quality, nor will voluntary efforts by doctors and health plans. . . . Ultimately this thing is going to require government intervention.'' Why would we want to encourage more people to enroll in private health plans given the managed care abuses igniting the Patient's Bill of Rights debate?

Medicare is the primary payer for the oldest elderly, chronically ill, disabled, and ESRD patients—all very complex and expensive groups to care for. Private managed care plans, which primarily control costs by restricting access to providers and services, simply do not meet the health care needs of everyone in this population. For the most part, Medicare+Choice plans have enrolled only the healthiest beneficiaries, while avoiding those most in need of care. There is no way of knowing whether or not private health plans are able to provide quality care to the sickest population.

Medicare beneficiaries will have significant difficulties making decisions in a market-based system. This is potentially the most disastrous consequence of moving to a fully privatized Medicare program. Many Medicare beneficiaries are cognitively impaired. Thirty percent of Medicare beneficiaries currently enrolled in managed care plans have low health literacy. That is they have difficulty understanding simple health information such as appointment slips and prescription labels. Now we're discovered that health plans often fail to provide critical information to potential enrollees. How can we expect senior citizens and the disabled to participate as empowered consumers in a free-market health care system, especially without essential information?

Medicare reform cannot be based solely on private sector involvement. More than 11 million Medicare beneficiaries—30% of the population—live in areas where private health plans are not available, and because of the limited number of providers probably never will be available. A comprehensive, viable, nationally-based fee-for-service program must be maintained for people who either cannot afford to limit their access to services in private managed care plans, or who are incapable of participating in a free market environment.

Unfortunately the debate surrounding privatizing Medicare is grounded in ideology, not fact. While I understand the need to improve and expand the choices available to Medicare beneficiaries—the Medicare+Choice program was created in recognition of this—we also have an obligation to preserve the promise of guaranteed, affordable health insurance for the people who need it most. The private sector is not a panacea for our problems. Historical experience proves that alternative solutions are necessary for our elderly and disabled citizens. Before we move to an entirely new system, we should attempt to improve the existing infrastructure, one that has served elderly and disabled citizens effectively for over thirty years.

ARIZONA ANTI—DEFAMATION LEAGUE HONORS DANIEL R. ORTEGA, JR.

HON. ED PASTOR

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 6, 1999

Mr. PASTOR. Mr. Speaker, I rise before you today to proudly bring tribute to a fellow Arizonan who has long exemplified the meaning of leadership, community, and good citizenship. He is a well-respected leader in Arizona and Phoenix, and someone whom I'm proud to call my friend—Mr. Daniel R. Ortega, Jr.

In my home state, Danny recently received the Leader of Distinction Award from the Arizona Region of the Anti-Defamation League.